

SOLICITATION AMENDMENT

Solicitation No. RFP YH990018 Amendment No. 01
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Solicitation Due Date August 20, 1999 3:00 P.M. MST

Arizona Health Care Cost
Containment System Administration
701 East Jefferson
Phoenix, Arizona 85034

Contracts Management Specialist
Douglas C. Peeples, CPPB, CPCM

A signed copy of this amendment must be returned with the proposal and received by AHCCCSA prior to the Solicitation due date and time. This solicitation is amended as follows:

1. Section A.I of the RFP indicated that proposals are to be received at AHCCCS by 3:00 p.m. local time August 12, 1999. The solicitation due date and time is hereby changed so that **proposals are now to be received at AHCCCS by 3:00 PM local time (MST) on August 20, 1999.**
2. Certain questions were asked in conjunction with the Pre-Proposal Bidders' Conference. The attached document contains those questions along with AHCCCSA's answers.
3. Further, for your information we have attached 2 tables that provide snapshots of the population served under this contract in the calendar year 1998.
4. All else remains unchanged by this amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.

Signature
Date: _____

Typed Name and Title

Name of Company

This Solicitation Amendment is hereby executed this 5th day of August 1999, in Phoenix, Arizona.

Michael Veit
As Contracts and Purchasing Administrator

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August 5, 1999

Questions raised by prospective offerors relating to AHCCCSA solicitation #YH990018 and AHCCCSA's answers thereto.

	<u>Prospective Offeror's Questions</u>	<u>AHCCCSA's Answers</u>
1.	Page 3, Travel Reimbursement: It is our assumption that mileage will not be reimbursable within Maricopa County – if not, should this be considered in the contracted rate?	AHCCCSA expects that travel be included in the contracted rate for prospective, concurrent, and retrospective reviews. Travel mileage should not be included in the contracted rate for the reinsurance audits. In these cases the Contractor's staff will accompany AHCCCSA staff in a state owned vehicle, and AHCCCSA will arrange and pay for any overnight accommodations. AHCCCSA will reimburse the Contractor for its employee's meals while on travel status, as long as the reimbursement is within the State's per diem limits.
2.	Page 3, Travel Reimbursement: What is the current rate for mileage reimbursement?	The State currently reimburses travel at the rate of 31 cents per mile.
3.	Page 8, Overview. PRO or PRO-like organization: Will the State require documentation of PRO or PRO-like status at the time of proposal submission? If so, what kind of documentation will be required?	AHCCCSA would expect to receive documentation from potential bidders that shows that they meet the PRO requirements found in 42 CFR Parts 462, and 434. The language of Part 462 provides specific staffing requirements for physician-sponsored PROs vs. physician-access PROs, or PRO like. Company organization and staffing, prior work experience with other state Medicaid or Medicare programs would show this. References may be checked to validate the work the bidder has done with other states.
4.	Page 8, General Service Requirements: Criteria - Does the State have a preference for criteria (i.e., InterQual) or will the vendor's developed criteria be acceptable?	Yes. The State prefers InterQual. A vendor's developed criteria will not be acceptable.
5.	Page 8, Overview: Please clarify that the State requires or prefers RN reviewers for prospective, concurrent and retrospective reviews.	AHCCCSA requires RN reviewer.
6.	Page 9, General Services: Please elaborate on focused reviews – typically how many hours should be allocated, and cite examples of past and/or future review topics. Can the vendor recommend specific focused reviews?	The focused reviews are done for predetermined reasons using selected sample cases. Criteria and case selections, as well as time frames, are based either on internally identified problem areas or the areas where the greatest potential benefit exists. The exact allocation of hours for focused reviews can't be predetermined. It will

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		<p>greatly depend upon the effort involved in the review.</p> <p>Example: “Retained products of conception.” This focused review was initiated because AHCCCSA felt that the percentage of occurrences of these cases was relatively high for the population group, compared to what one would expect an average industry acceptance rate of these incidences to be. However, the outcome of the focused review determined that although the overall percentage was high, these incidences occurred during a long period of time and the incidences did not always include same providers.</p> <p>The vendor can make specific recommendations, and AHCCCSA will evaluate each recommendation on its merit and other related factors.</p>
7.	Page 9, Service Objectives: According to URAC, Arizona has specific standards for process requirements on appeals and denials. Do these apply to the Medicaid population? If not, does the State have specific appeal timeframes and processes for the Medicaid program? If not, will the state accept URAC appeal guidelines for standard and expedited reviews?	<p>AHCCCSA’s standards may be found in several locations. The appeal process is contained in the AHCCCS Rules, which are A.A.C. Title 9 Chapter 22. The grievance and appeal process is contained in Article 8 of these rules, i.e., R9-22-801 et seq. A link to this rule may be found on the AHCCCS WWW homepage at www.ahcccs.state.az.us by clicking on “Resources” then following the “Administrative Rules” link. Further information pertaining to reconsideration may be found in the AHCCCS Medical Policy Manual (AMPM). The AMPM may also be found on the AHCCCS homepage. Again, click on “Resources”, then click on the link to “Guides and Manuals”, then “AHCCCS Medical Policy Manual.”</p> <p>In answer to the last question, no, AHCCCSA expects that the Contractor will follow the appeal guidelines contained in the Rules and the AMPM.</p>
8.	Exhibit B, Hospitals: Can the State provide data indicating the number of concurrent reviews conducted at each of the listed facilities?	<p>No. We do not have a breakdown by hospitals. However, the number of concurrent reviews performed by month is available. A copy is attached.</p>
9.	Page 9, Service Objectives: Does the State	<p>No. The State has no specific time</p>

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	require certain hours of operation for retrospective reviews (i.e. 8A-5P) or can this be at the discretion of the vendor to incorporate normal business hours?	requirements for retrospective reviews of hospital admissions. The vendor will need to take into account normal business hours of the hospital; however, reinsurance audit hours may vary slightly.
10.	When does the existing contract expire? What kind of transition can be expected?	The current contract expires on September 24, 1999. We expect an orderly and well-coordinated transition. The current contractor will be expected to fulfill all of its obligations under its existing contract. This may include any reviews that had been started prior to the award of the new contract.
11.	Please identify the software the State currently uses (i.e. Microsoft Word, Corel, etc.)?	The AHCCCSA network uses Microsoft Windows 4.0. Microsoft Office or Office 97 is installed on the desktops; this includes either Word 6.0 or Word 97, Excel 5.0, or Excel 7, Access, etc. The AHCCCSA business operating system uses custom designed software for its Medicaid Management Information System (PMMIS). This software is based on CA Datacom and uses Ideal. The AHCCCSA administrative operating system is based on ORACLE.
12.	Please identify the current contractor, the current contract term, the dollar award for State Fiscal Year 1998 and/or 1999.	The current contractor is the Health Services Advisory Group. The current contract was awarded on September 24, 1993. In State Fiscal Year 1998 AHCCCSA spent \$436,613.00 and in State Fiscal Year 1999 the amount was \$466,073.00.
13.	When does the State expect to make its determination and date of award?	The State expects to make its determination and make award of the contract prior to September 24, 1999.
14.	Will the State make available the names and/or companies who attend the bidder's conference?	This information was provided to those who attended at the bidder's conference.
15.	Will this contract have renewals for a second or third year option?	The contract is for one year with an option to extend up to a total of 5 years. AHCCCSA's practice is to extend contracts providing that acceptable services have been provided in one-year increments. Refer to Special Provision #12.
16.	Does the State require the Medical Director to be Arizona-licensed and Arizona based?	No. According to Arizona Statute (ARS § 32-1421 (B)), the Medical Director does not need to be licensed in Arizona as long as he/she is a doctor of medicine residing in another state who is authorized to practice medicine in that jurisdiction, if he/she engages in consultation regarding specific patient(s) with a doctor of medicine licensed in this state. The ARS may be accessed at the

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		ALIS WWW homepage at www.azleg.state.az.us/ars .
17.	Is a local office required for telephonic review if the offeror has demonstrated successfully the ability to handle telephonic review and service coordination activities remotely?	Concurrent and retrospective reviews are required to be conducted on-site.
18.	Must all key staff be identified in order to bid, or is the Department willing to give consideration to job descriptions and an aggressive training plan while actively recruiting?	It is expected that the vendor will have a team on board consisting of at least a Medical Director/Physician Advisor and nursing staff members at the start of the contract. Any additional staff can be added later on.
19.	Page 8, Concurrent review process: Is permission already in place for the vendor to visit the hospitals? Will the vendor need to obtain permission and or letter of agreement?	After the contract is awarded, AHCCCSA will send written communication introducing the vendor to all hospitals included in the "Exhibit B" of the RFP.
20.	What is the current process for long term hospitalized patients? Does the Department have a case management vendor in place to assist with alternate levels of care or is the part of the discharge planning process for the proposed vendor?	Long Term hospitalized patients are currently reviewed like all other hospitalized patients. There is no case management vendor in place. If a lower level of care is warranted, then it is the responsibility of the hospital to do the discharge planning. AHCCCSA's Prior Authorization Unit acts as a resource.
21.	Does the Department require providers to call in for prospective review several days prior to actual admission date? If so, what is the timeframe?	The provider must call by the day of a scheduled admission.
22.	Has it been the process for the vendor to call patients at home prior to admission to review the patient's admission, assess the patient's home situation, educate about length of stay and potential rehab services required for certain admission? Would this be considered part of the discharge planning process mentioned in the RFP?	The vendor has no contact with the patient prior to, during hospitalization or after the discharge.
23.	Could the State elaborate on its Prior Authorization Unit (PA) or direct us in obtaining the information?	Please refer to the "AHCCCS Medical Policy Manual- chapter 300-Medical policy for covered services". Refer to answer #7 for AHCCCS web site address.
24.	Could the Department expound on case denial reconsiderations? Is there a current process and timeframes in place that the Department desires? Can we assume that reconsideration is performed when the provider/physician supplies additional information to make a determination?	<p>When AHCCCSA denies payments for the service, the impacted parties, i.e. service provider or patient can ask for reconsideration based on the additional information. This occurs after the initial denial.</p> <p>Yes, AHCCCSA has a defined reconsideration process.</p> <p>One reconsideration is allowed within 60 days after the initial denial.</p>

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		Your assumption is correct, a reconsideration is performed when additional information is provided.
25.	Section E: Uniform Terms and Conditions (page 14) provides that materials, including reports, computer programs and other deliverables, created under this Contract are the sole property of the State. Vendor may propose to use medical criteria and software on which to run the criteria that has been developed using its own resources, without state funds or any federal financial participation. The development of both the criteria and software were unrelated to this Contract. The criteria and software are proprietary to the vendor and extreme measures are taken to protect its confidentiality. This question is to confirm that criteria and software as described above will not, consistent with Medicaid Regulations, be considered as created under this contract and, therefore, will remain the proprietary property of the bidder.	AHCCCSA affirms that this understanding is correct.
26.	Does the State want Offerors to include pricing information in the technical proposal, or should all cost information be separately bound?	The technical proposal should not include pricing information. Pricing information should be included in the separate business proposal. Refer to Submission Instructions #3.
27.	Section F.10 required that a certificate of insurance be submitted to AHCCCS within 10 days of notification of contract award. The Offeror's checklist lists the certificate of insurance as something that must be submitted with the proposal. Will the Offeror be required to include a completed insurance certificate in the proposal?	Refer to Submission Instructions #3, Content of Business Proposal. Here it states "The business proposal shall consist of ... and evidence that the offeror possesses the required insurance and can provide the required performance bond."
28.	Page 2, Section B, paragraph 2: How do you estimate travel?	Offerors should use their experience and judgment in estimating travel to be included in the contracted rate for prospective, concurrent, and retrospective medical reviews. See the answer to #1 above.
29.	Page 2, Section B, paragraph 3, item #7: how many hours do you estimate per audit?	The largest selected sample size is seventy-two events per audit. However, on average, an individual audit may consist of 35- 40 events. Review time for each event is approximately 25 minutes. "Event" means the number of completed stay(s) from admission to discharge in an inpatient hospital, sub-acute facility or nursing facility, which is due to one course of

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		treatment for an acute medical or emergency psychiatric episode. This may include multiple claims.
30.	Page 8, Section D, paragraph 2.E: Are RN's only required?	Yes.
31.	Page 10, Section D, paragraph 4.B (1): Please explain what is required for review of an infection surveillance system and risk control.	The State expects the vendor to recognize communicable diseases, standards of care for treatment of diseases, epidemiology, and risk management strategies while conducting concurrent reviews.
32.	Page. 10, Section D, paragraph 4.B (7): Can it be the Medical Director on behalf of the Physician Advisor? What is expected on interaction with the patient and family?	Yes. No interaction with patient and family expected. When requested by AHCCCSA, the patient's family or attending physician, it is expected that the Physician Advisor shall interact directly with the attending physician.
33.	Page. 10, Section D, paragraph 4.D, Retrospective Reviews: Do Type I and II retros have to be priced separately, as Type I involves travel?	Yes. However, usually Type I reviews are done by the vendor while conducting concurrent reviews at the same facility.
34.	Page 11, Section D, paragraph 5 A (5): What do you want reported under Sentinel events?	Any event that identifies a potential or actual problem.
35.	Page 12, Section D, paragraph 5 A (6): When you mention health plan, is that for reinsurance reporting only?	No.
36.	Page 12, Section D, paragraph 5 A (7): How does the offeror get ICD-9 codes and UB 92's? What if the success rate is less than 100%?	It is hope that the Offeror could get this information from the review summary (abstracts) of medical records at the time of conducting concurrent and retrospective reviews by referring to the ICD-9 Code Book. It is not expected that the vendor will re-review the medical record for final determination of diagnosis. (In order to identify specific healthcare trends, AHCCCSA and the vendor would meet after contract award to determine the optimum manner in which this information can be obtained.) If the success rate is not 100%, then State expects notification.
37.	Should the business proposal be submitted separately from the technical proposal?	Yes, see the answer to #26 above.

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AHCCCS Eligible Members

AUTHORIZED ACUTE HOSPITALIZATION & CONCURRENT REVIEW

Population Totals

	ESP ACUTE HOSP PA	IHS ACUTE HOSP PA	TOTAL PA ISSUED FOR ACUTE HOSP	TOTAL HSAG REFERRED
JAN	222	326	548	344
FEB	196	262	458	277
MAR	263	261	524	322
APRIL	225	261	486	311
MAY	255	296	551	382
JUNE	257	301	551	429
JULY	230	317	547	382
AUG	277	305	380	380
SEP	236	249	485	322
OCT	285	285	570	391
NOV	281	235	516	356
DEC	259	256	515	389
TOTAL	2986	3354	6131	4285

A total of 6131 authorizations where issued for acute hospitalization in 1998.

Of the 6131 authorization 2986 where issued for emergency services program members & 3354 where issued for Indian Health Service members.

Of the 6131 acute hospitalization 4285 where referred to the concurrent review agency.

Source: PA Unit

AHCCCS Eligible Members Fee-For-Service Population Totals

Date	ESP	IHS
January 1, 1998	3,957	50,790
February 1, 1998	3,792	51,179
March 1, 1998	3,988	51,285
April 1, 1998	4,130	50,965
May 1, 1998	4,364	51,123
June 1, 1998	4,474	50,968
July 1, 1998	4,600	50,812
August 1, 1998	4,807	50,937
September 1, 1998	5,010	50,681
October 1, 1998	4,897	49,757
November 1, 1998	4,967	49,375
December 1, 1998	4,897	49,874

Date	ESP	IHS
January 1, 1999	4,672	49,993
February 1, 1999	4,787	50,141
March 1, 1999	4,998	50,293
April 1, 1999	5,174	50,230
May 1, 1999	5,430	50,540
June 1, 1999	5,735	50,843
July 1, 1999		
August 1, 1999		
September 1, 1999		
October 1, 1999		
November 1, 1999		
December 1, 1999		

ESP indicates the Emergency Services Program, IHS indicates Indian Health Services.

Source: Eligibility & Enrollment Report, June, 1999 (DMS)